WOMACK ARMY MEDICAL CENTER
DEPARTMENT OF THE ARMY
WAMC STOP A
2817 REILLY ROAD
MXCX-DOS-GS - BARIATRICS
FORT BRAGG, NC 28310-7301

PHONE: (910)907-9927

SURGICAL WEIGHT LOSS PROGRAM

DATE: ___ /____/_____

Name_____

Address_____
Street City State Zip Code

Email address _____

TELEPHONE: Home _____Work _____Cell _____

SPONSOR'S SS#_____ PATIENT'S SS#: _____

Gender: __male ___ female Date of Birth ____/____/_____

Race:
__ Caucasian __Hispanic __African American __Asian __Native American __Other

Who Referred You? _____ Reason for Referral _____

Occupation:_____ Place of Employment: _____

Employment Status:

__Full time __Part time __Self-Employed __Homemaker __Student __Retired __Disabled

PEOPLE LIVING IN YOUR HOUSEHOLD

NAME	AGE	RELATIONSHIP

HEALTH CARE PROVIDERS/MEDICAL

Primary Care Physician: _____ Phone: _____
Address (if off-post): _____ Fax: _____

HEALTH CARE PROVIDERS – MENTAL HEALTH
Therapist or Mental health Counselor _____
Address: _____
Phone: _____ Fax: _____

Please list all other medical health providers and specialist. If you need more space, list additional providers' names, specialties, addresses, telephone and fax numbers on the back of this page.

Provider name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Alcohol, Tobacco, and Non-prescription Drug History

Current use: List all alcohol, tobacco, and non-prescription drugs and the amounts that you currently use. List any additional products on the back of this page.

	Type of Product	Amount per day	Per Week
Alcohol:	_____	_____	_____
	_____	_____	_____
Tobacco:	_____	_____	_____
	_____	_____	_____
Drugs:	_____	_____	_____
	_____	_____	_____

When did you stop or plan to stop using?
Alcohol: _____ Tobacco: _____ Drugs: _____

Family History

Please list any relatives that have a history of any the following conditions your parents, grandparents (maternal/paternal), siblings, or your children have ever experienced.
Obesity _____ Diabetes _____ Heart Disease _____ Stroke_____
High Cholesterol/Triglycerides _____ Cancer _____

Prescription Medications, Supplements and Remedies
Please list all your current medications, supplements and remedies. If you need additional space, please continue on the back of this page.

Prescription drugs, dosages and purpose (including psychiatric medication and birth control. Please use back of form for additional space.)

Medication	**Dosage/How Often**	**Purpose**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the counter drugs:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Vitamins/supplements/herbal remedies:

_____ _____

_____ _____

_____ _____

Allergies to prescription medications:

Allergy	Reaction

HOSPITALIZATIONS

Please list all inpatient hospitalizations, including psychiatric and substance abuse treatment. If you need additional room, please continue on the back of this page.

Approximate Date	Problem	Hospital/Treatment Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS NON-BARIATRIC SURGERIES

Procedure:

__ Anti-reflux procedure	__ Bowel resection	__ Breast cancer, mastectomy
__ Breast Cancer, biopsy	__Breast cancer, radiation	__ CABG
__ Removal of gallbladder	__Hip replacement	__ Hysterectomy
__ Knee replacement	__ Laminectomy	__Nissen Fundoplication
__ Peripheral vascular Procedure	__ Tubal ligation	__ Vasectomy
__ C-section	__ Other _____	

PREVIOUS BARIATRIC SURGERIES

__ Bilopancreatic diversion (BPD)	__Gastric banding, adjustable
__Gastric band, non-adjustable	
__Gastric bypass, (Roux-en-Y) open	__Gastric bypass(Roux-en-Y) laparoscopic
__ Sleeve gastrectomy	__Gastric bypass, mini loop
__Intestinal Bypass	__Gastric bypass, banded
__Vertical banded Gastroplasty	__BPD with duodenal switch

__Other (Please list) _____

Year: _____

Original weight: _____ lbs Estimated? ____ Actual?____

Lowest weight achieved _____ __lbs __ estimated __actual

Surgeon: _____

Have you ever had an adverse reaction to anesthesia/sedation? ___Y ___N
(If you answered yes, please comment) _____

Has any of your relative had an adverse reaction to anesthesia/sedation? __Y__N
(If you answered yes, please comment) _____

Current Medical Conditions

Please check box and add information.

Heart and Circulation: **Comments**

___Chest pain/coronary artery disease/angina _____
___Congestive Heart Failure _____
___Irregular or rapid heart beat (arrhythmias) _____
___Peripheral vascular disease _____
___Leg swelling (edema) _____
___Hypertension/high blood pressure _____
___Stroke _____
___Blood Clots/Deep Vein Thrombosis (DVT) _____
___Other:_____ _____

Lungs:

___ Shortness of breath _____
___at rest ____walking on flat ground __on stairs/hills
___Asthma _____
___COPD (emphysema, chronic bronchitis) _____
___Pulmonary Embolism (Blood clot in the lungs) _____
___Sleep Apnea _____ CPAP settings_____ _____
___Pulmonary Hypertension _____
___ Other: _____ _____

Gastrointestinal/GI:

___Gastro Esophageal Reflux (GERD) _____
___ Heartburn _____
___Ulcers _____
___Crohn's Disease/Ulcerative Colitis _____
___ Frequent Diarrhea _____
___Frequent constipation _____
___Gallbladder ___stones ____removed _____
___Fatty liver _____
___Colon ___hemorrhoids ___polyps _____
___Liver ____hepatitis _____Cirrhosis _____
___Other: _____ _____

Endocrine:

___Diabetes _____
___High cholesterol, high triglycerides _____
___Infertility _____
___Menstrual irregularities _____
___Polycystic Ovarian Syndrome _____
___Thyroid ____Hypothyroidism (Underactive) _____
____Hyperthyroidism (Overactive) _____
___Excessive hot or cold feeling _____

___Visual Changes _____
___Changes in your voice _____
___Recent increase in thirst or urination _____
___Abnormal hair growth _____
___Numbness or tingling in your hands or feet _____
___Other: _____ _____

MEDICAL HISTORY

Blood: **Comments**
___Anemia _____
___Iron Deficiency _____
___Other:_____ _____

Musculoskeletal:
___Back pain _____
___Gout _____
___Arthritis type: _____ _____
___Fibromyalgia _____
___Other: _____ _____

Psychiatric:
___Depression _____
___Bi-polar Disorder _____
___Eating Disorder ___Anorexia ___Bulimia _____
___Anxiety _____
___Other: _____ _____

Other:
___Urinary Stress Incontinence _____
___Pseudotumor Cerebi _____
___Abdominal Skin/Pannus irritation/infection _____
___Abdominal Wall Hernia _____
___Kidney Disease _____
___Kidney Stones _____
___Other: _____

WEIGHT AND WEIGHT LOSS HISTORY

Current weight or best estimate _____ Current Height_____
Weight 1 year ago _____
Are you at your highest weight ever? ___Yes ___No
If your answered no, what was your highest weight and when? _____

Please check all previous weight loss methods that you have tried. List any additional

Commercial diet programs
___Weight Watchers
___Diet Workshop
___Jenny Craig
___OA
___TOPS
___Nutrisystem
___Other:_____
___Other:_____

Prescription diet medications
___Redu (dexfenfluraramine)
___Pondimin (fenfluramine)
___Phen-Fen
___Phentermine (Fastin,Adipex)
___Amphetamines
___Meridia (sibutramine)
___Other:_____
___Other_____

Liquid Diets
___Optifast
___HMR
___Slimfast
___Other: _____

Herbal and non-prescription remedies
___Epedra, ma huang
___Other herbals: _____
___Over the counter diet aids
___Other:_____

WEIGHT AND WEIGHT LOSS HISTORY

Therapy and Other Programs
___Behavior therapy
___Psychotherapy
___Exercise programs
___Feeding Ourselves
___Self initiated or fad diets. Please list:
_____

Medical and health Care Treatments
___Previous gastric surgery/stapling
___Jaw wiring
___Other surgery:_____
___Acupuncture
___Hypnosis
___Other: _____

Cardiac Questionnaire

Gastric bypass is an intermediate risk surgery according to the American Heart Association. In order to best prepare you for surgery please fill out the following questions appropriately.

1. Have you had heart surgery with in the last 3 years?

2. Have you been seen recently by your heart doctor?

3. Do you have a heart condition? If yes, please describe.

4. Do you get chest pain with exercise?

5. Have you ever had a heart attack?

6. Have you been treated for heart failure?

7. Do you have diabetes mellitus?

8. Can you carry groceries in from the car?

9. Can you vacuum the house?

10. Can you mow the lawn using a push mower?

11. Have you ever had a stroke?

12. Do you have high blood pressure? Is it treated? Where is it normally at when you get it checked?

13. How fast can you walk a mile?

14. What is your age?

OBSTRUCTIVE SLEEP APNEA SCREENING QUESTIONAIRE

1. Do you snore loud enough to be heard through closed doors?

   Yes_____ No_____

2. Do you often feel tired, fatigued, or sleepy upon waking?
   Yes_____ No_____

3. Has anyone observed you stop breathing during your sleep?
   Yes_____ No_____

4. Do you have high blood pressure?
   Yes_____ (if yes) Are you being treated for it? Yes____No___
   No _____

5. Is your Body Mass Index more than 35?
   Yes_____ No_____
   (BMI= Your weight in pounds X 703/your height in inches X your height in inches)

6. Are you over 50 years old?
   Yes _____ No_____

7. Is your neck circumference greater than 40 cm?
   Yes_____ No _____

8. Are you a male?
   Yes _____ No_____